PERITONEAL DIALYSIS (PD) CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2001

[Before completing please read instructions at the bottom of this page and on pages 5 and 6]

PATIENT IDENTIFICATION

MAKE CORRECTIONS TO PATIENT INFORMATION ON LABEL IN THE SPACE BELOW

Place Patient Data Label Here

10a. Is Patient Hispanic? ☐Yes ☐ No ☐ Unknown

11. If the above patient information is incorrect make corrections in space above then continue to question 12. Please verify patient's race and check question 10a. above. If patient unknown or was not dialyzed in the unit at any time during Oct 2000 – Mar 2001 return the blank form to the Network.

12a. **Patient's height (MUST COMPLETE):** _____inches OR _____centimeters

12b. **Patient's weight (abdomen empty) (first clinic visit weight after Oct.1, 2000):** _____lbs. Or _____kg.

13. **Does patient have limb amputation(s):** ☐ Yes ☐ No

14. The most RECENT date this patient returned to peritoneal dialysis following: transplant failure, an episode of regained kidney function, or switched modality.

☐ Date _____/_____/_____ (month day year) ☐ N/A (NOTE: Check N/A if patient has remained on peritoneal dialysis since the beginning of a regular course of dialysis; date given in item 8 above)

Individual Completing Form **(Please print)** :

First name: _____ Last name: _____ Title: _____

Phone number: (_____) _____ - _____ Fax number (_____) _____ - _____

INSTRUCTIONS FOR COMPLETING THE PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2001

The label on the top left side of this form contains the following patient identifying information (#'s 1-8). If the information is incorrect make corrections to the right of the label.

1. LAST and first name.
2. DATE of birth (DOB) as MM/DD/YYYY.
3. SOCIAL Security Number (SSN).
4. HEALTH Insurance Claim Number (HIC).
5. SEX (1=Male; 2=Female; 3=Unknown).
6. RACE (1=American Indian/Alaskan Native; 2=Asian; 3=Black; 4=White; 5=Unknown; 6=Pacific Islander; 7=Mid East Arabian; 8=Indian Subcontinent; 9=Other Multiracial).
7. PRIMARY cause of renal failure by HCFA-2728 code.
8. DATE, as MM/DD/YYYY, that the patient began a regular course of dialysis.
9. ESRD Network number. Do not make corrections to this item.
10. Facility's Medicare provider number.

10a. Is the patient Hispanic? Check either Yes, No, or Unknown, as appropriate.

11. Review the patient and facility specific information contained on the pre-printed label. Please verify the patient's race, item 6 above. If any of the information is incorrect, write corrections in the space to the right of the label. If the patient is unknown or if the patient was not dialyzed in the unit at any time during Oct 2000 through Mar 2001, send the blank form back to the ESRD Network office with the name and address of the facility providing services to this patient on March 31, 2001, if known.

12a. Enter the patient's height in inches or centimeters. HEIGHT MUST BE ENTERED, do not leave this field blank, you may ask the patient his/her height to obtain this information. If the patient had both legs amputated, record pre-amputation height and check YES for item 13.

12b. Enter the patient's weight (abdomen empty) in pounds or kilograms. Use the FIRST CLINIC VISIT weight on or after October 1, 2000.

13. For the purpose of this study, check NO if this patient has had toe(s), finger(s), or mid-foot (Symes) amputation; but **check YES if this patient has had a below-knee, below-elbow, or more proximal (extensive) amputation.**

14. Enter the most recent date this patient returned to peritoneal dialysis following: transplant failure, an episode of regained kidney function, or switched modality. Check N/A if patient remained on peritoneal dialysis since the date of FIRST dialysis given in item 8 on Patient Data Label above.

PLEASE COMPLETE ITEMS 15 THROUGH 21 ON PAGES 2, 3, AND 4 OF THIS DATA COLLECTION FORM
INSTRUCTIONS FOR COMPLETING THESE ITEMS ARE ON PAGES 5 AND 6.

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2001(CONTINUED)

LAB DATA. The following data are requested for each 2-month time period: OCT-NOV2000, DEC 2000-JAN 2001, FEB-MAR 2001. For each question, where appropriate, use the **first** lab values obtained in each time period. **ENTER THE FOLLOWING CODES IN THE SPACES BELOW IF LAB VALUES CANNOT BE LOCATED:** **NF** if Not Found. **HOSP** if patient was hospitalized during the entire time period. **TRANS** if patient was absent during the entire time period.

15. HEMOGLOBIN: Enter the FIRST Hemoglobin (HGB) determined by the laboratory FOR EACH 2-MONTH TIME PERIOD: OCT-NOV 2000, DEC 2000-JAN 2001, FEB-MAR 2001. Also enter the prescribed WEEKLY EPO dose and the route of administration, the first Serum Ferritin concentration and Transferrin Saturation, and the route of iron administration for each time period.

	OCT-NOV 2000	DEC 2000-JAN 2001	FEB-MAR 2001
A. First laboratory hemoglobin during the two month time period:	____ ____ . ____ g/dL	____ ____ . ____ g/dL	____ ____ . ____ g/dL
B. Was there a **prescription** for EPO immediately before the above HGB was drawn?	☐ Yes ☐ No(go to 15E)	☐ Yes ☐ No (go to 15E)	☐ Yes ☐ No (go to 15E)
C. What was the **PRESCRIBED WEEKLY EPO** dose at the time immediately **BEFORE** the above HGB was drawn? (See instructions on page 5)	_____ units/wk	_____ units/wk	_____ units/wk
D. What was the prescribed route of EPO administration related to item 15C?	☐ IV ☐ SC	☐ IV ☐ SC	☐ IV ☐ SC
E. First Serum Ferritin concentration during the two month time period:	___ ___ ___ ___ ng/mL	___ ___ ___ ___ ng/mL	___ ___ ___ ___ ng/mL
F. First Transferrin Saturation during the two month time period:	____ ____ ____ %	____ ____ ____ %	____ ____ ____ %
G. Was iron prescribed at any time during the two month time period?	☐ Yes ☐ No(go to 16)	☐ Yes ☐ No(go to 16)	☐ Yes ☐ No(go to 16)
H. If yes, what was the route of iron administration? (check all that apply)	☐ IV ☐ IM ☐ P.O.	☐ IV ☐ IM ☐ P.O.	☐ IV ☐ IM ☐ P.O.

16. SERUM ALBUMIN: Enter the FIRST serum albumin FOR EACH 2-MONTH TIME PERIOD: OCT-NOV 2000, DEC 2000-JAN 2001, FEB-MAR 2001. Check the method used (green or purple) by the lab to determine the serum albumin. If method unknown, please call lab to find out. Do not leave blank.

	OCT-NOV 2000	DEC 2000-JAN 2001	FEB-MAR 2001
A. First serum albumin during the two month time period:	_____ . _____ gm/dL	_____ . _____ gm/dL	_____ . _____ gm/dL
B. Check lab method used: BCG = bromcresol green; BCP = bromcresol purple	☐ BCG ☐ BCP	☐ BCG ☐ BCP	☐ BCG ☐ BCP

17. PERITONEAL DIALYSIS ADEQUACY: The remainder of this form lists a series of questions regarding adequacy measurements for this patient. Please answer questions 17A and B FOR EACH 2-MONTH TIME PERIOD indicated. Then continue to pages 3 and 4.

	OCT-NOV 2000	DEC 2000-JAN 2001	FEB-MAR 2001
A. Was the patient on peritoneal dialysis at any time during this period?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B. Was the patient on hemodialysis or did patient receive a transplant at any time during this period?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2001 (CONTINUED)

18. ADEQUACY: The following data are requested for the FIRST ADEQUACY determination done during the months OCTOBER 2000 through MARCH 2001. Starting with the first adequacy measurement in these months, enter the adequacy measurements/results listed below that were obtained. (Please DO NOT record more than one adequacy measurement done for any one month.) Please read instructions on pages 5 and 6 before completing this section.

	☐ Check box if adequacy measurement was not done during OCT 2000-MAR 2001
18.A. Date of first adequacy measurement between 10-1-2000 to 3-31-2001	_____/_____/_____ (mm) (dd) (yy)
18.B. Patient's dialysis modality when adequacy measures were performed	☐ CAPD ☐ Cycler
18.C. Patient's weight at the time of this adequacy assessment (abdomen empty) (Circle lbs or kgs)	_____lbs /kgs
18.D. Weekly Kt/V_{urea} (dialysate and urine clearance)	____ . _____ _____
18.E. Method by which V above was calculated: Check one. (See instructions on page 5)	☐ %BW ☐ Hume ☐Watson ☐ Other
18.F. Weekly Creatinine Clearance (dialysate and urine clearance)	__ __ __ . __ L/wk
18.G. Is this Creatinine Clearance corrected for body surface area, using standard methods? (See instructions on page 6)	☐Yes ☐No
18.H. 24 hr DIALYSATE **volume** (prescribed and ultrafiltration)	___ ___ ___ ___ ___mL
18.I. 24 hr DIALYSATE **urea nitrogen**:	___ ___ ___ . ___ mg/dL
18.J. 24 hr DIALYSATE **creatinine:**	___ ___ . ___ mg/dL
18.K. 24 hr URINE **volume**: (If 24 hr urine was not collected check NP. If patient's urine production was negligible, i.e., <200 cc of urine/24 hr, then check anuric and go to question 18N)	___ ___ ___ ___ mL ☐ NP ☐ anuric
18.L. 24 hr URINE **urea nitrogen**:	___ ___ ___ . ___ mg/dL
18.M. 24 hr URINE **creatinine:**	___ ___ ___ . ___ mg/dL
18.N. SERUM BUN at the time this adequacy assessment was done	___ ___ ___ mg/dL
18.O. SERUM creatinine at the time this adequacy assessment was done	___ ___ . ___ mg/dL
18.P. 1. Most recent four hour dialysate/ plasma creatinine ratio (D/Pcr) from a peritoneal equilibration test (PET)	____ . _____ _____
2. Date of most recent D/Pcr	_____/_____/_____ (mm) (dd) (yy)

19. PERITONEAL DIALYSIS PRESCRIPTION: For the following questions – record the PD prescription in effect immediately prior to the time the adequacy measures/results recorded in Question 18 were performed. In addition, if the prescription was changed following the adequacy measurement, please record the new prescription in the column indicated. Please read instructions on Page 6 before completing this section.

	Prescription prior to date in 18A	New Prescription _____/_____/_____ (mm) (dd) (yy)
19.A. Number of dialysis days per week	_____ (# days)	_____ (# days)
19.B. **CAPD PRESCRIPTION** (this includes patients with one overnight exchange using an assist device)		
1. Total dialysate volume infused per 24 hours	_ _ _ _ _ _ mL/24 hrs	_ _ _ _ _ _ mL/24 hrs
2. Total number of exchanges per 24 hours (including overnight exchange)	_____ (# exchanges)	_____ (# exchanges)
19.C. **CYCLER PRESCRIPTION**		
1. Total dialysate volume infused per 24 hours	_ _ _ _ _ _ mL/24 hrs	_ _ _ _ _ _ mL/24 hrs
2. Total dialysis time a. Total nighttime dialysis time	____hrs____min	____hrs___min
b. Total daytime dialysis time	____hrs____min	____hrs___min
c. Total amount of time the patient is dry during 24 hours (**Note:** 2a+b+c = 24 hours)	____hrs____min	____hrs___min
3. Nighttime Prescription (excluding last bag fill) a. Volume of a single nighttime exchange	__ __ __ __ mL/exchange	__ __ __ __ mL/exchange
b. Number of dialysis exchanges during the nighttime	_____ (#/nighttime)	_____ (#/nighttime)
4. Daytime Prescription (including last bag fill) a. Volume of a single daytime exchange	__ __ __ __ mL/exchange	__ __ __ __ mL/exchange
b. Number of dialysis exchanges during the daytime	_____ (#/daytime)	_____ (#/daytime)
19.D. Does the prescription described above include TIDAL dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
19.E. Based on this adequacy result,		
1. Was the collection repeated?	☐ Yes ☐ No	
2. Was the prescription changed?	☐ Yes ☐ No	
Note: If this prescription was changed, enter the new prescription date and information in the adjacent column.		

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2001 (CONTINUED)

20. ADEQUACY: The following data are requested for the SECOND ADEQUACY determination during the months OCTOBER 2000 through MARCH 2001. Starting with the second adequacy measurement in these months, enter the adequacy measurements/ results listed below that were obtained. (Please DO NOT record more than one adequacy measurement done for any one month.) Please read instructions on pages 5 and 6 before completing this section.

	☐ Check box if a second adequacy measurement was not done during OCT 2000- MAR 2001
20.A. Date of second adequacy measurement between 10-1-2000 to 3-31-2001	_____/_____/_____ (mm) (dd) (yy)
20B. Patient's dialysis modality when adequacy measures were performed	☐ CAPD ☐ Cycler
20.C. Patient's weight at the time of this adequacy assessment (abdomen empty) (Circle lbs or kgs)	_____lbs /kgs
20.D. Weekly Kt/V_{urea} (dialysate and urine clearance)	____ . _____ _____
20.E. Method by which V above was calculated: Check one. (See instructions on page 5)	☐ %BW ☐ Hume ☐Watson ☐ Other
20.F. Weekly Creatinine Clearance (dialysate and urine clearance)	__ __ __ . __ L/wk
20.G. Is this Creatinine Clearance corrected for body surface area, using standard methods? (See instructions on page 6)	☐Yes ☐No
20.H. 24 hr DIALYSATE **volume** (prescribed and ultrafiltration)	___ ___ ___ ___ ___mL
20.I. 24 hr DIALYSATE **urea nitrogen**:	___ ___ ___ . ___ mg/dL
20.J. 24 hr DIALYSATE **creatinine:**	___ ___ . ___ mg/dL
20.K. 24 hr URINE **volume**: (If 24 hr urine was not collected check NP. If patient's urine production was negligible, i.e., <200 cc of urine/24 hr, then check anuric and go to question 20N)	___ ___ ___ ___ mL ☐ NP ☐ anuric
20.L. 24 hr URINE **urea nitrogen**:	___ ___ ___ . ___ mg/dL
20.M. 24 hr URINE **creatinine:**	___ ___ ___ . ___ mg/dL
20.N. SERUM BUN at the time this adequacy assessment was done	___ ___ ___ mg/dL
20.O. SERUM creatinine at the time this adequacy assessment was done	___ ___ . ___ mg/dL
20.P. 1. Most recent four hour dialysate/ plasma creatinine ratio (D/Pcr) from a peritoneal equilibration test (PET)	____ . _____ _____
2. Date of most recent D/Pcr	_____/_____/_____ (mm) (dd) (yy)

21. PERITONEAL DIALYSIS PRESCRIPTION: For the following questions – record the PD prescription in effect immediately prior to the time the adequacy measures/results recorded in Question 20 were performed. In addition, if the prescription was changed following the adequacy measurement, please record the new prescription in the column indicated. Please read instructions on Page 6 before completing this section.

	Prescription prior to date in 20A	New Prescription _____/_____/_____ (mm) (dd) (yy)
21.A. Number of dialysis days per week	_____ (# days)	_____ (# days)
21.B. **CAPD PRESCRIPTION** (this includes patients with one overnight exchange using an assist device)		
1. Total dialysate volume infused per 24 hours	_ _ _ _ _ _ mL/24 hrs	_ _ _ _ _ _ mL/24 hrs
2. Total number of exchanges per 24 hours (including overnight exchange)	_____ (# exchanges)	_____ (# exchanges)
21.C. **CYCLER PRESCRIPTION**		
1. Total dialysate volume infused per 24 hours	_ _ _ _ _ _ mL/24 hrs	_ _ _ _ _ _ mL/24 hrs
2. Total dialysis time		
a. Total nighttime dialysis time	____hrs____min	____hrs___min
b. Total daytime dialysis time	____hrs____min	____hrs___min
c. Total amount of time the patient is dry during 24 hours	____hrs____min	____hrs___min
(**Note:** 2a+b+c = 24 hours)		
3. Nighttime Prescription (excluding last bag fill)		
a. Volume of a single nighttime exchange	__ __ __ __ mL/exchange	__ __ __ __ mL/exchange
b. Number of dialysis exchanges during the nighttime	_____ (#/nighttime)	_____ (#/nighttime)
4. Daytime Prescription (including last bag fill)		
a. Volume of a single daytime exchange	__ __ __ __ mL/exchange	__ __ __ __ mL/exchange
b. Number of dialysis exchanges during the daytime	_____ (#/daytime)	_____ (#/daytime)
21.D. Does the prescription described above include TIDAL dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
21.E. Based on this adequacy result,		
1. Was the collection repeated?	☐ Yes ☐ No	
2. Was the prescription changed?	☐ Yes ☐ No	
Note: If this prescription was changed, enter the new prescription date and information in the adjacent column.		

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2001 (CONTINUED)

INSTRUCTIONS FOR COMPLETING QUESTIONS 15 THROUGH 17 (continued from page 1): To answer questions 15 through 17 review the patient's clinic or facility medical record FOR EACH 2-MONTH TIME PERIOD: OCT 1, 2000 through NOV 30, 2000, DEC 1, 2000 through JAN 31, 2001, and FEB 1, 2001 through MAR 31, 2001. Enter the following if the information cannot be located: NF if not found, HOSP if hospitalized during the entire time period, TRANS if patient was absent during the entire time period.

15.A: Enter the patient's FIRST hemoglobin (HGB) value determined by the laboratory for EACH 2-month time period: OCT-NOV 2000, DEC 2000-JAN 2001, FEB-MAR 2001.

15.B and 15.C: Check the appropriate box to indicate if there was a prescription for EPO IMMEDIATELY BEFORE the hemoglobin measurement reported in 15.A was obtained. If there was no prescription for EPO go to question 15E.

Enter the **PRESCRIBED** WEEKLY EPO DOSE at the time IMMEDIATELY BEFORE the hemoglobin measurement reported in 15.A was obtained, even if the patient did not receive the EPO dose **("Immediately before" refers to the week prior to the test).** If prescribed less frequently than weekly, divide the prescribed EPO dose by the number of weeks in the dosing interval to obtain weekly EPO dose. If the EPO dose is prescribed by the number of days, divide the dose by the number of days and multiply by 7 to obtain weekly EPO dose (example-EPO 5000 units every 10 days. 5000 units divided by 10 days and multiplied by 7 days equals 3500 units per week). If using the sliding scale for EPO dosing, total all the doses given during the week and enter the value. Enter 0 units if the patient was on "hold" immediately before the hemoglobin measurement **(for the purposes of this collection, a "hold" order will be considered a 0 unit prescribed dose).**

15.D: Check the appropriate space to indicate the prescribed route of administration for EPO (intravenous (IV) or subcutaneous (SC)).

15.E: Enter the patient's FIRST serum ferritin concentration recorded EACH 2-month time period: OCT-NOV 2000, DEC2000-JAN 2001, FEB-MAR 2001. If a serum ferritin concentration test was not performed every 2-month time period, enter the value for the time period when performed and record "NP" for the other time period(s).

15.F: Enter the patient's FIRST transferrin saturation recorded EACH 2-month time period: OCT-NOV 2000, DEC 2000-JAN 2001, FEB-MAR 2001. If a transferrin saturation test was not performed every 2-month time period, enter the value for the time period when performed and record "NP" for the other time period(s).

15.G: Check either "Yes" or "No" to indicate if iron was prescribed at any time during the 2-month time periods.

15.H: If the answer to 15.G is "Yes," please check the appropriate space to indicate the route of iron administration (intravenous (IV), intermuscular (IM), or by mouth (P.O.)) for each 2-month time period. Check every route of iron administration that was used during each time period.

16.A: Enter the patient's **FIRST** serum albumin value recorded EACH 2-month time period: OCT-NOV 2000, DEC 2000-JAN 2001, FEB-MAR 2001.

16.B: Check the method used by the laboratory to determine the serum albumin levels (bromcresol green or bromcresol purple). If you do not know what method the laboratory used, call the laboratory to find out this information. DO NOT LEAVE THIS QUESTION BLANK.

17.A: Check the appropriate response (yes or no) for each 2-month time period, indicating whether this patient was on peritoneal dialysis at any time during each of the specified 2-month time periods: OCT-NOV 2000, DEC 2000-JAN 2001, FEB-MAR 2001.

17.B: Check the appropriate response (yes or no) for each 2-month time period, indicating whether this patient was on hemodialysis or received a transplant at any time during each of the specified 2-month time periods: OCT-NOV 2000, DEC 2000-JAN 2001, FEB-MAR 2001.

INSTRUCTIONS FOR COMPLETING QUESTIONS 18 THROUGH 21: To answer questions 18 through 21 review the patient's clinic or facility medical record and provide the requested data for each of the first two adequacy measurements and PD prescriptions in effect immediately prior to the adequacy measurements during the months OCTOBER 2000 through MARCH 2001. DO NOT record more than one adequacy measurement done for any one month.

18.A: Enter the first date on which adequacy of dialysis was assessed for each measure obtained between OCT 1, 2000 through MAR 31, 2001. DO NOT record more than one adequacy measurement done for any one month. Check the labeled box above date area if an adequacy measurement was not done during the time frame.

18.B: Check the modality of peritoneal dialysis this patient was on at the time the corresponding adequacy of dialysis measure was obtained. CHECK either CAPD or Cycler.

18.C: Enter the patient's weight (with abdomen empty) at the clinic/facility visit when the adequacy measurements were obtained, circle lbs or kgs as appropriate.

18.D: Enter the TOTAL WEEKLY Kt/V_{urea} for the first adequacy measurement indicated on 18.A between OCT 1, 2000 through MAR 31, 2001. NOTE: If you have a value for weekly Kt/V_{urea} for this adequacy assessment, please complete the corresponding values for questions 18H-18.J for 24-hour dialysate volume, 24-hour dialysate urea (or creatinine) and question 18.K for 24-hour urine volume. If the patient is not anuric, complete the corresponding values for questions 18.L-18.M, the 24-hour urine urea (or creatinine), if these values are available. Enter NP for all values when not performed. If your unit calculates a daily Kt/V_{urea}, multiply this result by 7.0 and enter the result in the appropriate space(s). If this patient did not dialyze each day of the week, then multiply the daily Kt/V_{urea} by the number of days the patient did dialyze.

18.E: Check the method used to calculate the V in the Kt/V_{urea} measurement; % BW = percent of body weight; Hume and Watson are two nomograms used to calculate V based on several of these parameters - weight, height, age, gender. If method used to calculate V is not known, please call lab to ascertain method. Please do not leave blank.

18.F: Enter the TOTAL WEEKLY CREATININE CLEARANCE for the first adequacy measurement indicated on 18.A between OCT 1, 2000 through MAR 31, 2001. NOTE: If you have a value for weekly creatinine clearance for this adequacy assessment, please complete the corresponding values for questions 18.H-18.J for 24-hour dialysate volume, 24-hour dialysate urea (or creatinine) and question 18.K for 24-hour urine volume. If the patient is not anuric, complete the corresponding values for questions 18.L-18.M, the 24-hour urine urea (or creatinine), if these values are available. Enter NP for all values when not performed. If your unit calculates a daily creatinine clearance multiply this result by 7.0 and enter the result in the appropriate space(s). If this patient did not dialyze each day of the week, then multiply the daily creatinine clearance by the number of days the patient did dialyze.

PERITONEAL DIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2001 (CONTINUED)

18.G: Check Yes or No if the weekly creatinine clearance was normalized for body surface area (i.e., the result is multiplied by $1.73m^2$ and divided by the patient's body surface area (BSA)). Standard methods for establishing BSA are: the DuBois and DuBois method; the Gehan and George method; and the Haycock method. If you do not have this information, call the laboratory that provided the creatinine clearance value for this information. Please do not leave blank.

18.H, I, and J: Enter the measured 24-hour DIALYSATE volume (includes prescribed and ultrafiltration volumes), urea nitrogen and creatinine obtained for the first adequacy measurement obtained between OCT 1, 2000 through MAR 31, 2001. If a 24-hour dialysate volume, urea nitrogen or creatinine were NOT measured in this time period, enter NP (for not performed) in the appropriate spaces. ONLY ENTER ACTUAL MEASURED 24-HOUR DIALYSATE VOLUME. DO NOT ENTER AN EXTRAPOLATED DIALYSATE VOLUME. Please report the 24-hour dialysate volume as a combination of the prescribed fill volume and the ultrafiltration volume.

18.K, L, and M: Enter the 24-hour URINE volume, urea nitrogen and creatinine obtained for the first adequacy assessment obtained between OCT 1 2000 through MAR 31, 2001. ONLY ENTER ACTUAL MEASURED 24-HOUR URINE VOLUME—DO NOT ENTER AN EXTRAPOLATED URINE VOLUME. If 24-hour urine volume was not collected check NP for not performed, OR if the patient's urine production was negligible, i.e., <200 cc of urine/24 hours, then check anuric. If NP or anuric is checked, SKIP TO QUESTION 18N. If urine urea nitrogen and creatinine were NOT measured in this time period, enter NP in the appropriate spaces.

18.N, O: Enter the SERUM BUN and SERUM CREATININE obtained for the first adequacy assessment obtained between OCT 1, 2000 through MAR 31, 2001. Enter NP in the appropriate spaces for all time periods when not performed.

18.P. **(1)**Enter the most recent four hour dialysate/plasma creatinine ratio (D/Pcr) from a peritoneal equilabration test (PET). **(2)**Enter the date of the most recent D/Pcr. The test result and corresponding date of the most recent D/Pcr may be outside the 6-month time frame. If never performed record "NP".

19.: To respond to questions 19.A through 19.F record the peritoneal dialysis (PD) prescription in effect immediately prior to the first adequacy measures/results recorded in question 18 performed between OCT 1, 2000 through MAR 31, 2001. In addition, if the prescription was changed following the adequacy measurement, please record the new prescription in the column labeled "New Prescription" as well as indicating the date that the new prescription was initiated. Complete all items that are applicable.

19.A: Enter the number of days per week for which this patient undergoes peritoneal dialysis.

19.B: CAPD PRESCRIPTION. Use the CAPD prescription category for all CAPD patients including patients with one overnight exchange using an assist device. **(1)**Enter the total dialysate volume in mL infused over a 24-hour period and **(2)** the number of exchanges per 24-hour period **PRESCRIBED** for CAPD at the time the first adequacy measurements were performed.

19.C: CYCLER PRESCRIPTION. **(1)**Enter the total dialysate volume in mL infused over a 24-hour period. **(2)**Total dialysis time - (Note: 2a+b+c = 24 hours): **(2a)**Enter the total nighttime dialysis time, **(2b)**the total daytime dialysis time, and **(2c)**the total amount of time the patient is dry during 24 hours. If the patient is never dry in 24 hours enter a value of 0 hours. The hours entered in 2a,b,&c should equal 24 hours. **(3)**Nighttime Prescription (excluding last bag fill): **(3a)**Enter the volume of a single nighttime exchange and **(3b)**the number of dialysis exchanges during the nighttime **PRESCRIBED** for CYCLER NIGHTTIME at the time the first adequacy measurements were performed. Include in the CYCLER NIGHTTIME prescription only those exchanges provided by an automated device. DO NOT include in this category any last bag fill or option that the patient carries after unhooking from the cycler or any daytime dwells as these exchanges are recorded in the DAYTIME PRESCRIPTION information. If different inflow volumes are used, report average inflow volume. **(4)**Daytime Prescription (including last bag fill): **(4a)**Enter the volume of a single daytime exchange and **(4b)**the number of dialysis exchanges during the daytime **PRESCRIBED** for CYCLER DAYTIME at the time the first adequacy measurements were performed. Include in the CYCLER DAYTIME prescription only those exchanges performed after the patient disconnects from the cycler and/or a last bag fill or option that the patient carries during the day . ANY OTHER EXCHANGES PERFORMED USING THE CYCLER SHOULD BE INCLUDED UNDER CYCLER NIGHTTIME PRESCRIPTION. If different inflow volumes are used, report average inflow volume.

19.D: Check the appropriate box, yes or no, whether this patient's peritoneal dialysis prescription included TIDAL dialysis. TIDAL patients are cycler patients for whom the dialysate is partially drained between some exchanges.

19.E: Check the appropriate box, yes or no, indicating whether the adequacy collection was repeated, or the prescription changed, following the first adequacy measurement performed between OCT 1, 2000 through MAR 31, 2001. If the prescription was changed enter the new prescription in the column to the right.

20.A-O: See instructions for 18.A-18.O and complete for second adequacy measurement performed between OCT 1, 2000 through MAR 31, 2001. DO NOT record more than one adequacy measurement done for any one month. Check the labeled box above date area if a second adequacy measurement was not done during the time frame.

21.A-E: See instructions for 19.A-19.O and complete for the peritoneal dialysis (PD) prescription in effect immediately prior to the second adequacy measures/results recorded in question 20 performed between OCT 1, 2000 through MAR 31, 2001.